

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

05825 77  
Reg. Dist. No....

1. PLACE OF DEATH. COUNTY Carroll		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Maryland	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Maple Grove		LENGTH OF STAY In this place 15 yrs	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Maple Grove	
		STREET ADDRESS (If rural give location)	

3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) BRADLEY - M - ARMAACOST		(Month) June (Day) 30 (Year) 1951	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Jan 3 1936
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY High school	9. AGE last birthday 15 yrs.

13. FATHER'S NAME Allen A. Armaacost	14. MOTHER'S MAIDEN NAME Leelilah V Bixler	12. CITIZEN OF WHAT COUNTRY USA
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. ✓	17. INFORMANT Allen A. Armaacost, Manchester, Md
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## 18. MEDICAL CERTIFICATION

INTERVAL BETWEEN  
ONSET AND DEATH  
6 days 5 minutes

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Strangulation

979X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) 164a
(c)	

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. ACCIDENT (Specify) SUICIDE Suicide HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Home	(CITY OR TOWN) HAMPSTEAD	(COUNTY) Carroll	(STATE) Md
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

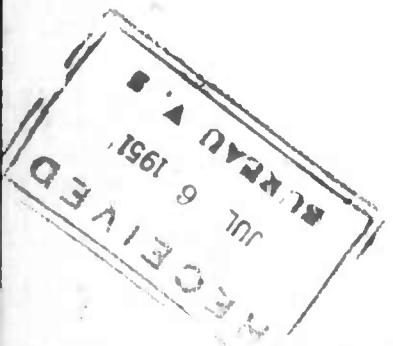
22. I hereby certify that I attended the deceased from ..... , 19....., to ..... , 19....., that I last saw the deceased

alive on ..... , 19....., and that death occurred at 6:45 P.m., from the causes and on the date stated above.

SIGNATURE Mayme C. Vinteford M.D. ADDRESS DATE SIGNED 7-2-51  
Degree or title Dr. ADDRESS DATE SIGNED 7-2-51

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF July 3 1951	NAME OF CEMETERY OR CREMATORIAL manchester	LOCATION (City, town, or county) Carroll Ed Ued	(State) Md
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DATE REC'D BY LOCAL REG. July 2, 1951	REG. JOHN L. HUGHES	REG. EDWARD E. TIPTON, HUMPTSTEAD	REG. ADDRESS
REG. ADDRESS			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05827

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH COUNTY <b>Carroll</b>			2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b>		
CITY (If outside corporate limits, write RURAL and LENGTH OF STAY OR give nearest town) <b>TOWN Rural - Sykesville</b>			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Silver Springs</b>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Springfield State Hospital</b>			STREET ADDRESS <b>10114 Dallas Avenue</b>		
3. NAME OF DECEASED (Type or Print)	(First) <b>Rose</b>	(Middle)	(Last) <b>Berlinsky</b>	4. DATE OF DEATH <b>June 24</b>	(Month) (Day) (Year) <b>19 51</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>5/12/90</b>	9. AGE last birthday <b>61</b> yrs.	If under 1 year Months Days Hours Min. If under 24 hrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
11. BIRTHPLACE (State or foreign country) <b>Baltimore - Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Samuel Lowery</b>			14. MOTHER'S MAIDEN NAME <b>Mary Benton</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		
17. INFORMANT AND ADDRESS <b>Hospital Records</b>			18. MEDICAL CERTIFICATION  I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  Immediate cause <b>Pneumonia, secondary, undetermined etiology</b> Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <b>Arteriosclerosis, heart disease w/r</b> Decubitus decompensations 12 hours Indef.		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Decubitus</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at m. Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR? ADDRESS	
22. I hereby certify that I attended the deceased from <b>April 20 1951</b> , to <b>June 24 1951</b> , that I last saw the deceased alive on <b>June 24</b> , 1951, and that death occurred at <b>4:00 P</b> m., from the causes and on the date stated above. SIGNATURE (Degree or title) <b>Henry E. A. Head M. D.</b> ADDRESS <b>Sykesville, Md.</b> DATE SIGNED <b>6/24/51</b>					
23. BURIAL, CREMATION REMOVAL (Specify) <b>Cremation</b>		DATE THEREOF <b>June 27, 1951</b>		NAME OF CEMETERY OR CREMATORIUM <b>Arlington Hall</b>	
DATE REC'D BY LOCAL REG. REC.		REGISTRAR'S SIGNATURE <b>Stanley Steer</b>		LOCATION (City, town, or county) (State) <b>Arlington Va.</b>	
24. FUNERAL DIRECTOR ADDRESS		<b>W. H. Chambers Co., Washington, D.C.</b>			

REF ID: A611661  
BUREAU X-5



RECEIVED

JUL 1 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Re 05828

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH COUNTY		CARROLL MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		SYKESVILLE, MD.		LENGTH OF STAY (In this place) 9 yrs., 4 mos.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		SPRINGFIELD STATE HOSPITAL		15 days	
3. NAME OF DECEASED (Type or Print)		(First) JAMES	(Middle) FRANK	(Last) BOLIN	4. DATE OF DEATH 6 22 1951
5. SEX	MALE	6. COLOR OR RACE	WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	SINGLE
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
				Agriculture	
13. FATHER'S NAME		James P. Bolin		11. BIRTHPLACE (State or foreign country)	
				South Carolina	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		No		12. CITIZEN OF WHAT COUNTRY?	
		None		U.S.A.	
16. SOCIAL SECURITY NO.		None		14. MOTHER'S MAIDEN NAME	
				Mary Jane Cook	
17. INFORMANT AND ADDRESS				Records, Springfield State Hospital	
18. MEDICAL CERTIFICATION					

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

## Immediate cause

(a) Tuberculous pneumonia, right base

4 weeks

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last

(b)

## Conditions contributing to the death but not related to the disease or condition causing death.

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour)		INJURY	HOW DID INJURY OCCUR?		
OF INJURY		m.	While at Work <input type="checkbox"/>	Not While At work <input type="checkbox"/>	

22. I hereby certify that I attended the deceased from 2-7-, 1942, to 6-22-, 1951, that I last saw the deceased

alive on 6-22-, 1951, and that death occurred at 4:20 A.m., from the causes and on the date stated above.  
SIGNATURE: (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)
Burial	6-26-51	Rocky Swamp Church	Rocky Swamp, S.C.	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
James 23, 1951	C. Harry Lee	John H. Haight - Sykesville Md		
		100105		

**RECEIVED** **BUREAU V. S.**  
JUN 23 1951  
WPA FILE NUMBER  
**RECEIVED** **BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05829

## CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)*	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	(If rural, give location)

*Carroll Maryland Carroll*

*Elmow Bridge Elmo*

*Maryland*

*Burke*

3. NAME OF DECEASED (Type or Print)	(First) HELEN	(Middle) R.	(Last) BROOKS	4. DATE OF DEATH	(Month) June	(Day) 30	(Year) 1951
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5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year	If under 24 hrs.
Female colored	Colored	Married	June 11-1898	53 yrs.	Months	Days

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	at home	Maryland	A. S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Daniel Green	Bethie blossom

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS	INTERVAL BETWEEN ONSET AND DEATH
No	none	Elmo Brooks, Elmow Bridge	

18. MEDICAL CERTIFICATION			
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I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
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Immediate cause	(a) Cardiac Failure	INTERVAL BETWEEN ONSET AND DEATH
415 X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	
93c	(c) Rheumatic C.V.D.	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
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21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, of office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
		INJURY			
TIME (Month) (Day) (Year)	(Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
OF INJURY	m.				

22. I hereby certify that I attended the deceased from Sept. 1, 1949, to June 30, 1951, that I last saw the deceased alive on June 29, 1951, and that death occurred at 4:30 P.M., from the causes and on the date stated above.
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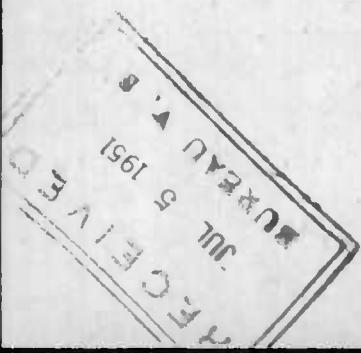
SIGNATURE *M. E. Robertson* ADDRESS *New Windsor, Md.* DATE SIGNED *6/30/51*

23. BURIAL, CREMATION REMOVAL (Specify)	DATE/TIME OF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)
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DATE REC'D BY LOCAL REGISTRY	REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
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July 7, 1951		Leslie J. Pepple	D. W. Hartley & Sons	
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Elmow Bridge & New Windsor Md.				
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MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

05830  
26

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
Carroll MARYLAND		Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN Ruiz-Westminster Md.		TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)		(First) (Middle) (Last)	
Benjamin		Brown	
4. DATE OF DEATH		(Month) (Day) (Year)	
June 7, 1951		19	
5. SEX		6. COLOR OR RACE	
Male Colored		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Carpenter self employed			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Peter Brown		Susan?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No			
17. INFORMANT		18. MEDICAL CERTIFICATION	
Moselle Smith 215 King St.			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause  919.1		(a) Shotgun wound of chest	
Antecedent cause(s)  184		(b) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last	
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY Farm	
TIME (Month) (Day) (Year) (Hour) OF INJURY 6-8-51 5:30 P.M.		(CITY OR TOWN) (COUNTY) (STATE) Rt. 140 2 miles east of Westminister Md.	
INJURY While at work <input type="checkbox"/> Not while work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? Firearms	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE  Stanley K. Durkach		ADDRESS M.D. 700 Fleet Street	
DATE SIGNED 6-9-51			
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF NAME OF CEMETERY OR CREMATORIAL REG. 6/12/1951 Anderson S.C.	
DATE REC'D BY LOCAL REG. 6/12/51		LOCATION (City, town, or county) (State) Anderson S.C.	
REG. 6/12/51		24. FUNERAL DIRECTOR Mrs. Katie R. Williams Schowen	
		ADDRESS 322 N. 510 346	

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05831

## CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place) <i>60 yrs.</i>	
TOWN <i>Westminster</i>		CITY (If outside corporate limits, write RURAL and give nearest town)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>15 John St.</i>		TOWN <i>Westminster</i>	
STREET ADDRESS <i>15 John St.</i>		STREET ADDRESS <i>15 John St.</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>Glade</i>	(Middle) <i>Livine</i>	(Last) <i>Buckingham</i>
4. DATE OF DEATH	(Month) <i>June</i>	(Day) <i>19</i>	(Year) <i>1951</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>married</i>	8. DATE OF BIRTH <i>May 7 - 1891</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bus driver - employee</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Bus Ridge</i>	9. AGE last birthday <i>60</i> yrs.
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>A.S.A.</i>	
13. FATHER'S NAME <i>Thomas Buckingham</i>		14. MOTHER'S MAIDEN NAME <i>Mary Henry</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-03-3232</i>	17. INFORMANT AND ADDRESS <i>Gladie Buckingham 15 John St. Westminster, Md.</i>
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <i>Carcinoma of rectum</i>			
154X Antecedent cause(s) (b) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last <i>46d</i>			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Cirrhosis of liver</i>			
19a. DATE OF OPERATION <i>May 3, 1951</i>		19b. MAJOR FINDINGS OF OPERATION <i>Carcinoma rectum</i>	
20. AUTOPSY?			
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>Apr. 1, 1951</i> , to <i>June 19, 1951</i> , that I last saw the deceased alive on <i>June 19, 1951</i> , and that death occurred at <i>4:50 A.M.</i> , from the causes and on the date stated above.			
SIGNATURE <i>Julius Charko</i>	(Degree or title) <i>Mr. D.</i>	ADDRESS <i>88 W Main Westminster, Md.</i>	DATE SIGNED <i>June 19, 1951</i>
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>June 22-1951</i>	NAME OF CEMETERY OR CREMATORIAL <i>Meadowlark Cemetery</i>	LOCATION (City, town, or county) (State) <i>Westminster, Md.</i>
DATE REC'D BY LOCAL REG. <i>6/20/51</i>	REGISTRAR'S SIGNATURE <i>Gloryann</i>	24. FUNERAL DIRECTOR ADDRESS <i>D. L. Farber &amp; Son Westminster, Md.</i>	

REVIEWED  
22-1951

LIBRARY U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Bc 05832

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>MARYLAND Maryland</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <b>Henryton</b>		LENGTH OF STAY (in this place) <b>12 days</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>HENRYTON STATE HOSPITAL</b>		3. NAME OF DECEASED (First) <b>EDNA</b>	
		(Middle) <b>MARIE</b>	
		(Last) <b>COOPER</b>	
4. DATE OF DEATH <b>JUNE 13 1951</b>	(Month)	(Day)	(Year)
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Nov. 27, 1922</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Private family</b>	9. AGE last birthday <b>28 yrs.</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>
13. FATHER'S NAME <b>Joseph Cooper</b>	14. MOTHER'S MAIDEN NAME <b>Ira (unknown)</b>	12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT AND ADDRESS <b>Deceased</b>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  Immediate cause <b>Pulmonary Tuberculosis</b>  Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <b>13b</b>  (a)  (b)  (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Nov., 1950</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <b>Yes <input type="checkbox"/> No <input type="checkbox"/></b>	
21. ACCIDENT SUICIDE HOMICIDE	(Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	m. While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	(STATE)
22. I hereby certify that I attended the deceased from May 31, 1951, to June 13, 1951, that I last saw the deceased alive on June 13, 1951, and that death occurred at 8:30 P.m., from the causes and on the date stated above. SIGNATURE <b>Elin P. Sauer M.D.</b> (Degree or title) ADDRESS <b>Henryton, Maryland</b> DATE SIGNED <b>6/13/51</b>			
23. BURIAL, CREMATION REMOVAL (Specify) <b>Cremation</b>	DATE THEREOF <b>6-18-51</b>	NAME OF CEMETERY OR CREMATORIAL <b>Mt. Zion Cem.</b>	LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>
DATE REC'D BY LOCAL REG. <b>6/12/51</b>	REGISTRAR'S SIGNATURE <b>Abdul A. Marshall</b>	24. FUNERAL DIRECTOR ADDRESS <b>Max Katie Williams 322 Rockwood</b>	

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BUREAU V. S.

JUN 19 1951

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05833

Reg. Dist. No. 74

## CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY Carroll		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland			
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Henryton		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 5 STREET ADDRESS 951 N. Durham Street			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Hospital		(If rural, give location)			
3. NAME OF DECEASED (Type or Print)	(First) ESTHER	(Middle) PAULINE	(Last) CORNISH		
4. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Sep.	8. DATE OF BIRTH Jan. 5, 1913		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory	10b. KIND OF BUSINESS OR INDUSTRY Canning	9. AGE last birthday 38 yrs.	11. BIRTHPLACE (State or foreign country) Goldenhill, Maryland		
13. FATHER'S NAME Clarence Meekins	14. MOTHER'S MAIDEN NAME Rhoda Lane	12. CITIZEN OF WHAT COUNTRY?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 214-07-9406	17. INFORMANT AND ADDRESS Deceased			
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
002X Immediate cause (a) Pulmonary Tuberculosis Nov., 1935					
136 Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from May 26, 1950, to June 26, 1951, that I last saw the deceased alive on June 26, 1951, and that death occurred at 6:45 A.M., from the causes and on the date stated above.					
SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED		
Eliza P. Lamm M.D. Henryton, Maryland 6/26/51					
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF June 30, 1951	NAME OF CEMETERY OR CREMATORIAL Kettle Cemetery	LOCATION (City, town, or county) Dover	(State) Md.	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE Albert R. Swankham	24. FUNERAL DIRECTOR ADDRESS			



BUREAU U.S.  
FBI

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05834

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED STATE Washington, D. C. COUNTY —		
CITY (If outside corporate limits, write RURAL and LENGTH OF STAY OR give nearest town) Sykesville since 3/29/44 TOWN			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital			STREET ADDRESS 4716 Blagden Avenue (If rural, give location)		
3. NAME OF DECEASED (Type or Print)	(First) Frank	(Middle) P.	(Last) DRONEY	4. DATE OF DEATH June 12	(Month) (Day) (Year) 1951
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) married	8. DATE OF BIRTH 3/8/70	9. AGE last birthday 81	If under 1 year Months yrs. If under 24 hrs. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lithographer			10b. KIND OF BUSINESS OR INDUSTRY Lithography		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY United States		
13. FATHER'S NAME Martin Droney			14. MOTHER'S MAIDEN NAME Unknown MARY DORSEY		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown			16. SOCIAL SECURITY NO. Unknown		
17. INFORMANT AND ADDRESS Records - Springfield State Hospital			18. MEDICAL CERTIFICATION		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) Edema of lungs. INTERVAL BETWEEN ONSET AND DEATH 2-3 hrs.					
4222 Antecedent cause(s) (b) Chronic myocarditis and myocardial degeneration ½ year Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with cerebral arteriosclerosis 7 years					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Montb) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sept. 1, 1947, to June 12, 1951, that I last saw the deceased alive on June 12, 1951, and that death occurred at 10, 25 am., from the causes and on the date stated above. SIGNATURE Martin Gross, M.D. (Degree or title) ADDRESS DATE SIGNED Martin Gross, M.D. Sykesville, Maryland June 12, 1951					
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF 6-16-51		NAME OF CEMETERY OR CREMATORIAL ABBEY MAUSOLEUM LOCATION (City, town, or county) ARLINGTON (State) VA.	
DATE REC'D BY LOCAL REG. <i>June 14, 1951</i>		REGISTRAR'S SIGNATURE <i>Chas. H. Keen</i>		24. FUNERAL DIRECTOR <i>Gray A. Foley - Catonsville, Md.</i> ADDRESS	

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MUN 18 1951

BUREAU V. S.

1697

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

05835

Reg. Dist. No. 74

1. PLACE OF DEATH COUNTY CARROLL MARYLAND CITY (If outside corporate limits, write RURAL and LENGTH OF STAY OR give nearest town) TOWN SYKESVILLE, MD. 11 YEARS HOSPITAL OR STATE HOSPITAL INSTITUTION OR STREET ADDRESS SPRINGFIELD			2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY ALLEGHENY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MARYLAND STREET ADDRESS 601 N. MECHANIC STREET (If rural, give location)		
3. NAME OF DECEASED (Type or Print) CHARLES ARTHUR DUCKWORTH			4. DATE OF DEATH 6 21 1951		
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SEPARATED	8. DATE OF BIRTH JUNE 15, 1902	9. AGE last birthday 49 yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER			10b. KIND OF BUSINESS OR INDUSTRY		
13. FATHER'S NAME CHARLES DUCKWORTH			11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) UNKNOWN			12. CITIZEN OF WHAT COUNTRY U.S.A.		
16. SOCIAL SECURITY NO. UNKNOWN			17. INFORMANT AND ADDRESS RECORDS OF SPRINGFIELD STATE HOSPITAL		
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) Bleeding from perforated stomach ulcer About 1 hr					
540.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause (b) chronic alcoholism with more than 11 yrs. (c) paranoid psychosis. 117a					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work m. Not While At work		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sept. 1, 1947, to June 21, 1951, that I last saw the deceased alive on June 15, 1951, and that death occurred at 6:30 A.m., from the causes and on the date stated above.					
SIGNATURE Martin Gross, M.D.		(Degree or title) ADDRESS Sykesville, Maryland		DATE SIGNED June 21, 1951	
23. BURIAL, CREMATION REMOVAL (Specify) Removal		DATE THEREOF 6/21/51		NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) BELLCITY MARY	
DATE REC'D BY LOCAL REG. June 27, 1951		REGISTRAR'S SIGNATURE Ottaway Heer		ADDRESS Frances A. Hensley	
770 600					

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JUN 26 1951

BUREAU Y.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05836

## CERTIFICATE OF DEATH

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING  
 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age  
 is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland		COUNTY Carroll			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		STREET ADDRESS RD. 4			
TOWN Rural Westminster				TOWN Rural Westminster		(If rural, give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS RD. 4				STREET ADDRESS RD. 4					
3. NAME OF DECEASED (Type or Print) WILLIAM Adolphus		(First) (Middle) (Last) EBANGH		4. DATE OF DEATH June 29 1951		(Month) (Day) (Year)			
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) married	8. DATE OF BIRTH 11-14-1883	9. AGE last birthday 67	If under 1 year yrs.	If under 1 year Months	If under 24 hrs. Days	If under 24 hrs. Hours	If under 24 hrs. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Adolphus Peterough		14. MOTHER'S MAIDEN NAME Mary Jane Langling							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT AND ADDRESS		18. MEDICAL CERTIFICATION			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		INTERVAL BETWEEN ONSET AND DEATH					
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work m. Not While At work		HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from March 1951, to June 29, 1951, that I last saw the deceased alive on June 28, 1951, and that death occurred at 1:30 A.m., from the causes and on the date stated above.		SIGNATURE (Degree or title) M.D.		ADDRESS		DATE SIGNED 6/30/51			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF July 1-1951		NAME OF CEMETERY OR CREMATORIAL CENTER Cemetery		LOCATION (City, town, or county) Westminster		(State) Md.	
DATE REC'D BY LOCAL REG. 6/30/51		REG. NUMBER		24. FUNERAL DIRECTOR		ADDRESS			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05837

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <i>MARYLAND</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Rural Elktonville Md 2475</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Baltimore</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Springfield State Hospital</i>		STREET ADDRESS <i>(If rural, give location)</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>JAMES</i>	(Middle) <i>J.</i>	(Last) <i>Egan</i>
4. DATE OF DEATH <i>June 22 1951</i>	(Month) <i>June</i>	(Day) <i>22</i>	(Year) <i>1951</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH <i>1879</i>
9. AGE <i>72 yrs.</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Transportation</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stenographer</i>	10b. KIND OF BUSINESS OR INDUSTRY	14. MOTHER'S MAIDEN NAME <i>Ellen Lyons unknown</i>	17. INFORMANT AND ADDRESS <i>Records of Springfield State Hospital</i>
13. FATHER'S NAME <i>Edward Egan</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No known</i>	16. SOCIAL SECURITY NO. <i>unknown</i>	18. MEDICAL CERTIFICATION <i>Chronic hypertension Cardiovascular disease with failure</i>
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  Immediate cause <i>443X</i> Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>93d</i> (a) <i>Chronic hypertension Cardiovascular disease with failure</i> → 10 days (b) <i>3 days</i> (c)			
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <i>19b. MAJOR FINDINGS OF OPERATION</i>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>		
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>INJURY</i>	(CITY OR TOWN) <i>(CITY OR TOWN)</i>	(COUNTY) <i>(COUNTY)</i>
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>m.</i>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <i>7:00 m.</i>	
22. I hereby certify that I attended the deceased from <i>9/1</i> , 19 <i>27</i> , to <i>6/22</i> , 19 <i>51</i> , that I last saw the deceased alive on <i>6/22</i> , 19 <i>51</i> , and that death occurred at <i>7:00</i> m., from the causes and on the date stated above. SIGNATURE <i>Henry Edward Egan M.D. Sykesville Md</i> ADDRESS <i>DATE SIGNED</i> <i>6/25/51</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>June 26 1951</i>	NAME OF CEMETERY OR CREMATORIY <i>New Cathedral</i>	LOCATION (City, town, or county) <i>Baltimore</i>
DATE REC'D BY LOCAL REG. <i>6/25/51</i>	REGISTRAR'S SIGNATURE <i>a w Hedrick</i>	FUNERAL DIRECTOR <i>CHAS F. EVANS &amp; Son</i>	ADDRESS <i>118 W Mt. Royal Avenue</i>

## MARYLAND STATE DEPARTMENT OF HEALTH

05838

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH COUNTY <b>Carroll</b>			2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>MARYLAND Maryland</b>		
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>TOWN Sykesville</b>			LENGTH OF STAY (in this place) <b>one -</b>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Springfield State Hospital</b>			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Solomons</b>		
3. NAME OF DECEASED (First) <b>Elmer</b>			4. DATE OF DEATH <b>EVANS June 4 1951</b>		
(Middle) —			(Month) (Day) (Year)		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>single</b>	8. DATE OF BIRTH <b>8/4/80</b>	9. AGE last birthday <b>70 yrs.</b>	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>light chores</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>undescribed</b>		
13. FATHER'S NAME <b>Augustus Evans</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		
15. WAS DECRASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>			12. CITIZEN OF WHAT COUNTRY <b>United States</b>		
16. SOCIAL SECURITY NO. <b>unknown</b>			14. MOTHER'S MAIDEN NAME <b>Mary Norwood</b>		
17. INFORMANT AND ADDRESS <b>Records - Springfield State Hospital</b>			18. MEDICAL CERTIFICATION		

MARGIN RESERVED FOR BINDING

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH		
Immediate cause <b>422.1</b>			<b>(a) Chronic myocarditis and myocardial degeneration</b> 3 years		
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last <b>93d</b>			<b>(b) Arteriosclerosis</b> 10 yrs. (?)		
(c) ---					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Mental deficiency</b>			70 yrs.		
19a. DATE OF OPERATION ---			19b. MAJOR FINDINGS OF OPERATION ---		
21. ACCIDENT SUICIDE HOMICIDE ---			PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY ---		
TIME (Month) (Day) (Year) (Hour) OF INJURY ---			INJURY OCCURRED While at Work Not While At work How did injury occur? ---		

22. I hereby certify that I attended the deceased from Sept. 1, 1947, to June 3, 1951, that I last saw the deceased

alive on June 3, 1951, and that death occurred at 7:00 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED  
**Martin Gross, M.D.** **Sykesville, Maryland** **6/4/51**

23. BURIAL, CREMATION REMOVAL (Specify) <b>removal</b>		DATE THEREOF <b>6/11/51</b>	NAME OF CEMETERY, OR CREMATORIAL <b>University Med School</b>	LOCATION (City, town or county) <b>Baltimore Md</b>	(State) <b>Md</b>
DATE REC'D BY LOCAL REG. <b>June 11, 1951</b>		REGISTRAR'S SIGNATURE <b>C. Henry Alvar</b>	24. FUNERAL DIRECTOR ADDRESS <b>James A. Hensley 538 W. Bidder St</b>		

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REFEVIEW

JUN 12 1952

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

05839

Reg. Dist. No. 74

1. PLACE OF DEATH COUNTY <b>CARROLL</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>MARYLAND</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>TOWN Rural - Sykesville</b>		LENGTH OF STAY (In this place) <b>13 hours</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Springfield State Hospital</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Baltimore</b>	
3. NAME OF DECEASED (First) <b>FRANK</b>		STREET ADDRESS <b>2311 McElderry Street</b>	
(Middle) <b>B</b>		(Last) <b>FRECKER</b>	
4. DATE OF DEATH <b>6 22 1951</b>		(Month) (Day) (Year)	
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <b>Retired</b>		8. DATE OF BIRTH <b>Jan. 10-1890</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sergeant</b>		9. AGE last birthday <b>61 yrs.</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md</b>	
13. FATHER'S NAME <b>Frank Frecker</b>		12. CITIZEN OF WHAT COUNTRY? <b>Minnie Gran</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Record, Springfield State Hospital</b>	
17. INFORMANT <b>History of chronic alcoholism with Delirium Tremens ?</b>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Acute pulmonary edema			
307 X Antecedent cause(s) (b) Hypostatic bronchopneumonia			
107 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY?		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/> at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <i>James T. Sharratt, Deputy Medical Examiner</i>		ADDRESS <i>Wilmington, Del</i>	
DATE SIGNED <i>6/22/51</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>June 26-51</b>	
NAME OF CEMETERY OR CREMATORIUM <b>Balto. National Cem.</b>		LOCATION (City, town, or county) <b>Balto. Md</b>	
REG. DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>6/25/51 A.W. Henderick John L. Miller</b>		ADDRESS <b>2334 Jefferson St.</b>	
24. FUNERAL DIRECTOR			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05840

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH. COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	COUNTY
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Sykesville	STREET (If rural, give location)	Baltimore
3. NAME OF DECEASED (Type or Print)	(First) Carroll	(Middle) Clark	(Last) Death
5. SEX	6. COLOR OR HAIR COLOR	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	4. DATE OF DEATH JULY 24 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	8. DATE OF BIRTH JULY 17 1865	9. AGE last birthday 85 yrs.
FATHER'S NAME Stephen P. Heath	11. BIRTHPLACE (State or foreign country) France	12. CITIZEN OF WHAT COUNTRY? Margaret Smith	13. MOTHER'S MAIDEN NAME 604 Edmondson Ave
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS Dr. Lola Physic, Edmondson St	18. MEDICAL CERTIFICATION Lobar Pneumonia chr. Myocarditis Hypertension
INTERVAL BETWEEN ONSET AND DEATH 4 days			

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) \_\_\_\_\_

443X Antecedent cause(s)  
Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last  
108(b) \_\_\_\_\_  
(c) \_\_\_\_\_

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from JULY 2, 1951, to JUNE 24, 1951, that I last saw the deceasedalive on JUNE 24, 1951, and that death occurred at 7-30 m., from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED JUNE 24 1951

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>JUNE 27 1951</u>	NAME OF CEMETERY OR CREMATORIAL <u>LONDON C.R.</u>	LOCATION (City, town, or county) <u>BALTIMORE</u>
DATE REC'D BY LOCAL REG.	REG. <u>6/25/51</u>	REGISTRAR'S SIGNATURE <u>A W Hedrick</u>	24. FUNERAL DIRECTOR <u>Henry A. Hutchins, 4101 Edmondson Ave</u>

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05841

Reg. Dist. No. X

## CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY <b>Carroll County</b> MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Md.</b> COUNTY		
CITY (If outside corporate limits, write RURAL and LENGTH OF STAY OR give nearest town) <b>Sykesville</b> (in this place) TOWN			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Sykesville</b>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Springfield State Hospital</b>			STREET ADDRESS <b>(If rural, give location)</b> <b>Springfield State Hosp.</b>		
3. NAME OF DECEASED (Type or Print) <b>Arthur H. GERMAN</b>		(First) (Middle) (Last)		4. DATE OF DEATH <b>June 19 1951</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWER, DIVORCED. (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>5-31-53</b>	9. AGE last birthday yr. <b>68</b>	If under 1 year Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Artist</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Newspaper</b>		
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13. FATHER'S NAME <b>Lemuel GERMAN</b>			14. MOTHER'S MAIDEN NAME <b>Eunice PIERCE</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>			16. SOCIAL SECURITY NO. / / / /		
17. INFORMANT AND ADDRESS <b>Springfield State Hospital</b>			18. MEDICAL CERTIFICATION		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) <b>Coronary occlusion, with myocardial infarction, left ventricle wall</b>					
Antecedent cause(s) (b) <b>Hypertensive cardiovascular disease</b>					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>93d</b>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Schizophrenia, paranoid type</b>					
19a. DATE OF OPERATION / / /		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		(Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input checked="" type="checkbox"/> Not While Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>5 1947</b> , to <b>June 19, 1951</b> , that I last saw the deceased alive on <b>June 18, 1951</b> , and that death occurred at <b>12 a.m.</b> , from the causes and on the date stated above.					
SIGNATURE (Degree or title) ADDRESS DATE SIGNED					
<i>Virginia Pierce</i> M. D. Sykesville, Maryland 6/19/51					
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>6/22/51</b>		NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State) <b>Lorraine Cem.</b> <b>Woodlawn, Md.</b>	
DATE REC'D BY LOCAL REG. REC'D.		REG. REC'D.		24. FUNERAL DIRECTOR ADDRESS <b>J. W. Reddick</b> <b>John J. Schinner &amp; Sons</b> <b>44, 45 Baeto. Md.</b>	

## MARYLAND STATE DEPARTMENT OF HEALTH

05842

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 78

MARGIN RESERVED FOR BINDING  
 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH. COUNTY Carroll		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Westminster		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 36 Madison St.		STREET ADDRESS 178 W. Main St.	
3. NAME OF DECEASED (Type or Print) CHARLES E. GREENHOLTZ		4. DATE OF DEATH June 21 1951	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Sept. 17-1916
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labour		10b. KIND OF BUSINESS OR INDUSTRY Coal yard	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Howard Greenholtz		14. MOTHER'S MAIDEN NAME Mollie Dentz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-12-2547	17. INFORMANT AND ADDRESS Elizabeth Hale Greenholtz, Westminster, R.D. 2. Md.
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH 20 months.	
Immediate cause (a) Cerebral Atrophy, Premature (355) Antecedent cause(s) (b) _____ 154b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION May 1951	19b. MAJOR FINDINGS OF OPERATION Osteomyelitis Localized R+ Parietal = Dilation of Ventricle		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED White at m. Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 15 July 1950, to 21 June 1951, that I last saw the deceased alive on 21 June 1951, and that death occurred at 4:10 p.m., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED Gellen Moulton M.D. Westminster, Md. 6/21/51			
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF June 24, 1951	NAME OF CEMETERY OR CREMATORIAL Meadowbranch Cemetery	LOCATION (City, town, or county) Westminster, Md. (State)
DATE READ BY LOCAL REG. 6/23/51	REGISTER'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS H. Barkard Son Westminster, Md.	

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 83

1. PLACE OF DEATH. COUNTY		Carroll MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE		Maryland COUNTY		
CITY (If outside corporate limits, write RURAL and OR TOWN <i>Rural Gist</i> )		LENGTH OF STAY <i>98 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rural -- Gist</i>		<i>Gist</i>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		(If rural, give location) R.D. Sykesville		
3. NAME OF DECEASED (Type or Print)		(First) WILLIAM	(Middle) K.	(Last) GRIMES	4. DATE OF DEATH	(Month) June	(Day) 4	(Year) 1951
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>Married</i>	8. DATE OF BIRTH <i>11-24-1864</i>	9. AGE last birthday <i>86</i> yrs.	If under Months	1 year Days	If under 24 hrs. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer (retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own farm</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.</i>				
13. FATHER'S NAME <i>David Grimes</i>		14. MOTHER'S MAIDEN NAME <i>Martha Ann Parrish</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT AND ADDRESS <i>Mrs. Sarah Grimes, Sykesville, Md.</i>					

18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause <i>Myocarditis (Chr)</i>		(a) <i>Nephritis (Chr)</i>		INTERVAL BETWEEN ONSET AND DEATH			
592X Antecedent cause(s) <i>131a</i>		(b) <i>Hypertension</i>					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>131a</i>		(c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from <i>May 1945</i> , to <i>6-4-51</i> , that I last saw the deceased alive on <i>6-3-51</i> , and that death occurred at <i>4:30 A.m.</i> from the causes and on the date stated above.			
SIGNATURE <i>W. C. Bennett Jr.</i>		ADDRESS <i>Westminster May 6-5-51</i>	DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL	DATE <i>6-6-1951</i>	NAME OF CEMETERY OR CREMATORIAL <i>Providence</i>	LOCATION (City, town, or county) (State) <i>Carroll Co. Md.</i>
DATE REC'D. BY LOCAL REG.	REGISTRAR'S SIGNATURE <i>Edua M Hewitt</i>	24. FUNERAL DIRECTOR C. M. Waltz, Winfield, Md.	

REFUGEE

JULY 9 1951

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VS ALF  
PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05844

## CERTIFICATE OF DEATH

Reg. Dist. No. 71

1. PLACE OF DEATH COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>MARYLAND</i> COUNTY <i>Maryland</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Mountaintown</i>		LENGTH OF STAY (in this place) <i> lifelong</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Main Street</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Mountaintown</i> STREET ADDRESS <i>Main Street</i>	
3. NAME OF DECEASED (Type or Print) <i>FRANK H Haines</i>		4. DATE (Month) (Day) (Year) OF DEATH <i>June 21 1951</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>M</i>	8. DATE OF BIRTH <i>1/7/1887</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>owner &amp; operator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>store</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.</i>	
13. FATHER'S NAME <i>Ellenberry Haines</i>		14. MOTHER'S MAIDEN NAME <i>Emma Binkard Haines Formatt</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>      </i>	
17. INFORMANT AND ADDRESS <i>Maud Haines, Mountaintown</i>		18. MEDICAL CERTIFICATION <i>Cerebral Hemorrhage</i> <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH <i>26 hr</i></span>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  Immediate cause <i>443X</i> (a) <i>Cerebral Hemorrhage</i> Antecedent cause(s) <i>93d</i> (b) <i>Arteriosclerotic C-V disease &amp; hypertension</i> <span style="float: right;"><i>years</i></span> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>August 1950</i> , to <i>June 21, 1951</i> , that I last saw the deceased alive on <i>June 20, 1951</i> , and that death occurred at <i>7 A.M.</i> , from the causes and on the date stated above. SIGNATURE <i>James T. March</i> ADDRESS <i>Wilmington Md</i> DATE SIGNED <i>June 28/51</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>cremated</i>		DATE THEREOF <i>June 23-1951</i>	NAME OF CEMETERY OR CREMATORIAL <i>Methodist Cemetery Mountaintown Maryland</i> LOCATION (City, town, or county) <i>Mountaintown Maryland</i> (State)
DATE REC'D BY LOCAL REG. <i>June 23/51</i>	REGISTRAR'S SIGNATURE <i>Margaret F. Engle</i>	24. FUNERAL DIRECTOR ADDRESS <i>Dr Hartshorne &amp; Sons 2906 1/4 New Windsor &amp; Union Bridge, Md</i>	

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH. COUNTY Carroll		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Henryton		CITY (If outside corporate limits, write RURAL and give nearest town) OR GOWN Baltimore 31, STREET ADDRESS 121 N. Bond Street	
HOSPITAL OR INSTITUTION OR STREET ADDRESS HENRYTON STATE HOSPITAL		(If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) LEON	(Middle)	(Last) JOHNSON
4. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	4. DATE OF DEATH June 12 1951
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motorman		10b. KIND OF BUSINESS OR INDUSTRY Baugh's Chemical Co.	8. DATE OF BIRTH Jan. 30, 1904 9. AGE last birthday 47 yrs. 11. BIRTHPLACE (State or foreign country) Baltimore, Md.
13. FATHER'S NAME Unknown		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, If unknown) No		16. SOCIAL SECURITY NO. 218-03-7700	17. INFORMANT AND ADDRESS Deceased
18. MEDICAL CERTIFICATION			

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

Immediate cause (a).... Pulmonary Tuberculosis

Dec., 1948

Antecedent cause(s) (b).... Heart Condition

May, 1951

Disease or conditions, if any, giving rise to the above cause  
stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month)	(Day)	(Year)	INJURY OCCURRED While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR? Not While At work <input type="checkbox"/>	
OF INJURY	m.				

22. I hereby certify that I attended the deceased from Sept. 24, 1949, to June 12, 1951, that I last saw the deceased

alive on June 12, 1951, and that death occurred at 1:55 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF 6/13/51	NAME OF CEMETERY OR CREMATORIAL McGaffey	LOCATION (City, town, or county) Brooklyn	(State)
DATE REC'D BY LOCAL REG. 6-12-51	REGISTRAR'S SIGNATURE Albert R. Smethurst	24. FUNERAL DIRECTOR Shroy C. Wilson	ADDRESS 6604 1/2 Brookly	ark.

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JUN 18 1951

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05846

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH CITY OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS	Carroll MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	Maryland Baltimore 18	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	Rural Sykesville 239 mos		LENGTH OF STAY (In this place)	(If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Springfield State Hospital		STREET ADDRESS	3904 Caucroary Road	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month) (Day) (Year)
Male	White		JONES	June	17 1951
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	AGE last birthday yrs.	If under 1 year Months Days Hours Min.
		MARRIED	96/77	73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Railroad		10b. KIND OF BUSINESS OR INDUSTRY	Transport	
13. FATHER'S NAME	Wm H. Jones		11. BIRTHPLACE (State or foreign country)	Baltimore Md	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or date of service)	No		12. CITIZEN OF WHAT COUNTRY	USA	
16. SOCIAL SECURITY NO.	420-0-932		17. INFORMANT AND ADDRESS	Laura Kong Hospital records	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) Acute exacerbation 3 days					
Antecedent cause(s) (b) Chronic arterio sclerotic heart disease Subacute					
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) Pulmonary fibrosis arrested over 10 yrs					
stating the underlying cause last					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. My chronic cerebral arteriosclerosis 5/22					
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
INJURY					
TIME (Month) (Day) (Year)	(Hour)	INJURY OCCURRED While at m. Work At work	HOW DID INJURY OCCUR?		
OF INJURY					
22. I hereby certify that I attended the deceased from 9/24, 1948, to 6/17, 1951, that I last saw the deceased alive on 6/17, 1951, and that death occurred at 2:30 p.m., from the causes and on the date stated above.					
SIGNATURE	(Degree or title)		ADDRESS	DATE SIGNED 6/17/51	
Signature Carl Head M.D. Sykesville, Md					
23. BURIAL, CREMATION REMOVAL, (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)	
Burial	6-20-51	Loudon Park	Baltimore, Md.		
DATE REC'D BY LOCAL REG. No. 11, 1951	REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
Signature Carl Harry Wur					
Wm Cook, Inc. 1217 & Paul St.					

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JUN 31 1951

BUREAU U. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

15847

Reg. Dist. No. 74

1. PLACE OF DEATH COUNTY		Carroll MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE		Maryland COUNTY			
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Sykesville 8 years		STREET ADDRESS		Rural (If rural, give location)			
3. NAME OF DECEASED (Type or Print)		(First) Amelia	(Middle)	(Last) Krell		4. DATE OF DEATH	(Month) June	(Day) 1	(Year) 1951
5. SEX	6. COLOR OR RACE	white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH	9. AGE last birthday	10. IF under 1 year Months	11. If under 24 hrs. Days	12. Hours	13. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Unknown		/		Germany		Germany			
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ? Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>123-45-6789</i>		17. INFORMANT AND ADDRESS Springfield State Hospital records	
18. MEDICAL CERTIFICATION									
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH									
Immediate cause		(a)		Coronary embolism		INTERVAL BETWEEN ONSET AND DEATH			
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b)		Arteriosclerosis		1 hour			
94a		(c)		Senile psychosis		9 yrs.			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.									
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?					
21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour)		OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 1, 1950, to June 1, 1951, that I last saw the deceased alive on June 1, 1951, and that death occurred at 6:15 A.m., from the causes and on the date stated above.									
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED			
<i>Walther H. Journeycake M.D.</i>				Springfield State Hospital		6/1/51			
Sykesville, Maryland									
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIAL		LOCATION (City, town, or county)		(State)	
Burial		6/1/51		University Med School		Baltimore		Md	
DATE REC'D BY LOCAL REG.		REG.		REG.		24. FUNERAL DIRECTOR		ADDRESS	
June 11, 1951		Frances A. Hemsley		Frances A. Hemsley		578 N. Biddle St.			

RECEIVED

JUN 6 1951

BUREAU Y. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05848

Reg. Dist. No. 76

## CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY Carroll MARYLAND CITY (If outside corporate limits, write RURAL and LENGTH OF STAY OR give nearest town) Smallwood (in this place)			2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Maryland COUNTY Carroll CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster STREET ADDRESS R. 6 (If rural, give location) Smallwood		
3. NAME OF DECEASED (First) Martha (Middle) Alice (Last) Lockard			4. DATE OF DEATH (Month) June (Day) 25 (Year) 1951		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH August 6, 1901	9. AGE last birthday 49 yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Carroll County, Md.	
13. FATHER'S NAME William S. Creswell			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. -----		
17. INFORMANT AND ADDRESS Wm. O. Lockard Smallwood, Md.			18. MEDICAL CERTIFICATION		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH <i>Toxine of lung - 4 weeks</i>		
163X Immediate cause (a) <i>Toxine of lung -</i>					
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last					
47d (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY			(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While Work <input type="checkbox"/> m. <input type="checkbox"/> <i>at work</i> <input type="checkbox"/>			HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>June 10</i> , 1951, to <i>June 25</i> , 1951, that I last saw the deceased alive on <i>June 25</i> , 1951, and that death occurred at <i>10:30 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>Brother Ben</i> ADDRESS <i>Westminster Maryland</i> DATE SIGNED <i>6/30/51</i>					
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>June 28, 1951</i>		NAME OF CEMETERY OR CREMATORIAL <i>Deer Park Cemetery</i>	LOCATION (City, town, or county) (State) <i>Smallwood Maryland</i>	
DATE REC'D BY LOCAL REG. <i>6/26/51</i>	REGISTRAR'S SIGNATURE <i>H. Alexander</i>		24. FUNERAL DIRECTOR ADDRESS <i>John R. Byers Westminster, Md.</i>		

**RECEIVED**

JUL 1 1951

**BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05849

## CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH CITY OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND		USUAL RESIDENCE (HOME) OF DECEASED CITY OR TOWN STREET ADDRESS	
Carroll County Westminster, Md. Rural				Westminster, Carroll County Westminster, Md. Rural	
3. NAME OF DECEASED (Type or Print)	(First) JOSHUA	(Middle) I	(Last) LOGUE	4. DATE OF DEATH	(Month) June 2 (Year) 1951
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months Days Hours Min.
male	white	single	9/2/1863	87 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
James		retired		Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY	
		none		U. S.	
17. INFORMANT AND ADDRESS					
Helene H. Logue Westminster, Md.					
18. MEDICAL CERTIFICATION					
INTERVAL BETWEEN ONSET AND DEATH					
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause					
443X Antecedent cause(s)					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last					
131a					
(a) Cardiovascular Renal disease 1 yr. myocardial degeneration & Valvular arteritis sclerotic coronary hypertension.					
(b) 1 yr. cholesterol					
(c)					
2. OTHER SIGNIFICANT CONDITIONS					
Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb., 1951, to June 2, 1951, that I last saw the deceased alive on June 1, 1951, and that death occurred at 7:45 P.M., from the causes and on the date stated above.					
SIGNATURE		(Degree of title)		ADDRESS DATE SIGNED	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIUM LOCATION (City, town, or county) (State)	
DATE RECEIVED BY LOCAL REG. 9/4/51		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	

**RECEIVED**

U.S. BUREAU OF INVESTIGATION

JUN 6 1951

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05850

82

Reg. Dist. No.

## CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY		Carroll MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		Ridgeville LENGTH OF STAY In this place		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)		(First) JAMES	(Middle) T.	(Last) MAGERS	4. DATE OF DEATH June 27 1957
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	SINGLE	8. DATE OF BIRTH 1-1-1887	9. AGE last birthday 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during regular working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Sel. Job		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Theophilus Magers		14. MOTHER'S MAIDEN NAME Mary E. Harris		12. CITIZEN OF WHAT Country?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. -----		17. INFORMANT AND ADDRESS N.W. Magers, Mt. Airy, Md.	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
<p>Immediate cause (a) Acute Cardiac Disease</p> <p>422.2 Antecedent cause(s) (b) Chronic Myocarditis Diseases or conditions, if any, giving rise to the above cause 93d stating the underlying cause last (c) Cardiac Ascaris 1 gr</p>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from April 4, 1957, to June 27, 1957, that I last saw the deceased alive on June 27, 1957, and that death occurred at 20 min., from the causes and on the date stated above. SIGNATURE ADDRESS DATE SIGNED John Doe, M.D. Mt. Airy, Md. 6/27/57					
23. BURIAL, CREMATION REMOVAL (Specify) BURIAL		DATE THEREOF 6-30-1951		NAME OF CEMETERY OR CREMATORIAL Pine Grove LOCATION (City, town, or county) Mt. Airy, Md. (State)	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE John D. Fingard		24. FUNERAL DIRECTOR C. M. Waltz, Winfield, Md.	



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05851

## CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE	
<i>Carroll</i>		MARYLAND <i>7 Md.</i> <i>Carroll</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)	
TOWN		STREET ADDRESS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		(If rural, give location)	
at Home		<i>Main St</i>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<i>Sadie Grace Wassenheimer</i>		June 20-1951	
SEX		5. COLOR OR RACE	
Female		White	
6. CLOTHES		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	
white		Single	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		8. DATE OF BIRTH	
reduced		Dec-31-1876	
10b. INDUSTRY		9. AGE last birthday	
Banking		74 yrs.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
Manchester - Md.		U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>John E. Wassenheimer</i>		<i>Lillian Rachel Hadden</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		216-09-0697-A	
17. INFORMANT		18. MEDICAL CERTIFICATION	
<i>Mrs. S. Wassenheimer (bro) Manchester</i>			
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <i>Cerebral hemorrhage</i> 9 days			
Antecedent cause(s) (b) <i>Hypertension</i> 20 yrs.			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>D</i>			
20. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Diabetes mellitus</i> 15 yrs.			
21a. DATE OF OPERATION		21b. MAJOR FINDINGS OF OPERATION	
22. I hereby certify that I attended the deceased from <i>June 16</i> , 19 <i>51</i> , to <i>June 20</i> , 19 <i>51</i> , that I last saw the deceased alive on <i>June 14</i> , 19 <i>51</i> , and that death occurred at <i>2</i> m., from the causes and on the date stated above.			
SIGNATURE (Degree or title)		ADDRESS DATE SIGNED	
<i>Marline C. Partefeld, M.D.</i>		<i>Sammons Key, Md</i> 6/20/51	
23. BURIAL, CREMATION OR REMOVAL (Specify)		DATE THEREOF NAME OF CEMETERY OR CREMATORIUM LOCATION (City, town, or county) (State)	
burial		<i>June 23-51 Reformed Church Cemetery Manchester - Md.</i>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE	
6/21/51		Pal & Co. Inc. Sluwa & Morris Pa. - Baltimore Md.	
24. FUNERAL DIRECTOR		ADDRESS	
J. D. J. D.			
25. VS. A15		26. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.	

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05852

## CERTIFICATE OF DEATH

Reg. Dist. No. 76

## 1. PLACE OF DEATH

COUNTY Carroll

CITY (If outside corporate limits, write RURAL and  
OR give nearest town)  
TOWN Rural, Westminster about 30ys

MARYLAND

LENGTH OF STAY  
(In this place)HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS Center St. Etal.

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland

COUNTY Carroll

CITY (If outside corporate limits, write RURAL and give nearest town)  
OR  
TOWN Rural, WestminsterSTREET (If rural, give location)  
ADDRESS Center St. Sptl.3. NAME OF  
DECEASED  
(Type or Print)

(First) ETHEL

(Middle) MARIE

(Last) MC GEE

4. DATE  
OF  
DEATH

June 4

(Day) (Year)

## 5. SEX

## 6. COLOR OR RACE

white

white

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Table worker

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

Married

INDUSTRY

## 8. DATE OF BIRTH

Sept 16, 1908

44

yrs.

## 9. AGE last birthday

If under  
Months

1 year

If under  
Days

24 hrs.

If under  
Hours

Min.

## 13. FATHER'S NAME

Christopher Shettle

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

220-03-3000

## 10b. KIND OF BUSINESS OR

Industry

store factory

medical

## 11. BIRTHPLACE (State or foreign country)

Maryland

Carroll Co. Md.

U.S.A.

## 12. CITIZEN OF WHAT

Country

## 14. MOTHER'S MAIDEN NAME

Sarah Myers

George Mc Gee, Westminster, Md.

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

## 18. MEDICAL CERTIFICATION

Coronary Occlusion

INTERVAL BETWEEN  
ONSET AND DEATH

30 min.

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last

Hypertensive Cardio Vascular Disease

5 years

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

5/21/51

Fract. Fibula Closed Reduction

## 20. AUTOPSY?

Yes  No 21. ACCIDENT  
(Specify)

SUICIDE

HOMICIDE

PLACE (Home, farm, factory, street,  
of office bldg., etc.)

INJURY Home

(CITY OR TOWN)

Westminster

Carroll Md.

Accident

TIME (Month) (Day) (Year) (Hour)

OF

INJURY

May 19 1951 pm.

INJURY OCCURRED

While at Not While

Work  At work 

HOW DID INJURY OCCUR?

Turned ankle on a step.

22. I hereby certify that I attended the deceased from 5/21, 1951, to 6/4, 1951, that I last saw the deceased

alive on 6/4, 1951, and that death occurred at 10 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

G Allen Moulton MD. Westminster Md.

6/5/51

23. BURIAL, CREMATION  
REMOVAL (Specify)

Burial

DATE

REG.

1951

REG.

NAME OF CEMETERY OR CREMATORIUM

Meadow Branch Cemetery

Rural, Westminster Md.

LOCATION (City, town, or county) (State)

Branch Cemetery, Rural, Westminster Md.

690491

REG.

RECEIVED

JUN 7 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05853

Reg. Dist. No. 74

## CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Henryton LENGTH OF STAY (in this place) 1 mth. 9 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 23, STREET ADDRESS (If rural, give location) 212 N. Amity St.,	
HOSPITAL OR INSTITUTION OR STREET ADDRESS HENRYTON STATE HOSPITAL		4. DATE OF DEATH June 26 1951	
3. NAME OF DECEASED (Type or Print) CARROLL	(First)	(Middle)	(Last)
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH June 30, 1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	9. AGE last birthday 55 yrs.
13. FATHER'S NAME Eleven McGlotten		11. BIRTHPLACE (State or foreign country) Cambridge, Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 219-07-5938	12. CITIZEN OF WHAT COUNTRY?
17. INFORMANT AND ADDRESS Deceased		14. MOTHER'S MAIDEN NAME Mary Henley	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Pulmonary Tuberculosis Aug., 1950			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work m.	HOW DID INJURY OCCUR? Not While At work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from May 17, 1951, to June 26, 1951, that I last saw the deceased alive on June 26, 1951, and that death occurred at 10:28 P.m., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED			
Elmer P. Samu M.D. Henryton, Maryland 6/26/51			
23. BURIAL, CREMATION REMOVAL (Specify) Survival	DATE THEREOF 7-2-51	NAME OF CEMETERY OR CREMATORIAL BALTIMORE	LOCATION (City, town, or county) BALTIMORE (State)
DATE REG'D BY LOCAL REG. 6/26/51	REGISTRAR'S SIGNATURE ALBERT R. SMITH	24. FUNERAL DIRECTOR R. W. Walling	ADDRESS
Deputy Reg. 1			

REFERENCE  
BUREAU U.S.  
MAY 1981

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05854

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Md.</i> COUNTY <i>Carroll</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town) OR	
TOWN <i>Russell - Sykesville</i>		TOWN <i>Russell - Sykesville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET (If rural, give location) ADDRESS <i>Gaithers Road.</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>Beulah</i>	(Middle) <i>C.</i>	(Last) <i>Parker</i>
4. DATE OF DEATH	Month <i>June</i>		Day <i>20</i>
5. SEX <i>F.</i>	6. COLOR OR RACE <i>col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Sept 18 1902</i>
9. AGE last birthday If under 1 year Months <i>48</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waitress</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Confectionery</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
13. FATHER'S NAME <i>George Gaither</i>	14. MOTHER'S MAIDEN NAME <i>Eliza Holland</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>212-24-3190</i>	17. INFORMANT AND ADDRESS <i>Russell &amp; Jefford - Sykesville, Md.</i>	
18. MEDICAL CERTIFICATION <i>Cerebral hemorrhage</i> <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i></span>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  331X Immediate cause <span style="float: right;">(a) <i>Cerebral hemorrhage</i></span> 83a Antecedent cause(s) <span style="float: right;">(b) <i>Stating the underlying cause last</i></span> 83a Diseases or conditions, if any, giving rise to the above cause <span style="float: right;">(c) <i></i></span>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) <span style="float: right;">(COUNTY) <span style="float: right;">(STATE)</span></span>
TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>6/17/1951</i> , to <i>6/20/1951</i> , that I last saw the deceased alive on <i>6/19/1951</i> , and that death occurred at <i>3 A.M.</i> , from the causes and on the date stated above. SIGNATURE <i>E. Martin, M.D.</i> ADDRESS <i>Roxbury, Carrollton, Md.</i> DATE SIGNED <i>6/21/51</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>6/22/51</i>	NAME OF CEMETERY OR CREMATORIUM <i>White Rock</i>	LOCATION (City, town, or county) <i>Sykesville, Carroll, Md.</i> (State) <i>Md.</i>
DATE REC'D BY LOCAL REG. <i>June 21, 1951</i>	REGISTRAR'S SIGNATURE <i>C. Harry Warner</i>	24. FUNERAL DIRECTOR ADDRESS <i>Luther H. Height - Sykesville, Md.</i>	

REF ID: V1159  
JUN 25 1961  
RECEIVED

## MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05855

Reg. Dist. No.

76

## CERTIFICATE OF DEATH

1. PLACE OF DEATH. COUNTY Carroll			2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Maryland COUNTY Carroll		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Westminster			LENGTH OF STAY <sup>In this place</sup> 30 years		
HOSPITAL OR INSTITUTION OR STREET ADDRESS 43 W. Main Street			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster		
3. NAME OF DECEASED (First) (Type or Print) Helen			4. DATE OF DEATH June 7 (Month) (Day) (Year) 1951		
5. SEX Female White			6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify) Married		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife			10b. KIND OF BUSINESS OR INDUSTRY		
13. FATHER'S NAME John A. Harman			8. DATE OF BIRTH Nov. 1, 1909 9. AGE last birthday 41 yrs. If under 1 year Months Days Hours Min.		
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 213-05-1695 17. INFORMANT AND ADDRESS Charles Norman Petry Westminster, Md.		
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
<p>Immediate cause (a) Carcinoma of Ovary 2 yrs</p> <p>Antecedent cause(s) (b) Metastases to Liver &amp; Chest 6 mo</p> <p>Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) Tumour &amp; Cachexia</p>					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION Sept 6-1949		19b. MAJOR FINDINGS OF OPERATION Ca. R. Ovary. + adhesions		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sept 1, 1949, to June 7, 1951, that I last saw the deceased alive on June 7, 1951, and that death occurred at 4:30 P.M. from the causes and on the date stated above. SIGNATURE ADDRESS DATE SIGNED Agnes Speicher Westminster, Md. 6/8/51					
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF Jun 10, 1951		NAME OF CEMETERY OR CREMATORIAL St. Luke's (Winters)	
DATE HANDLED BY LOCAL REG. 6/9/51		REGISTRAR'S SIGNATURE J. Alexander		LOCATION (City, town, or county) (State) near New Windsor, Md.	
24. FUNERAL DIRECTOR ADDRESS John R. Byers Westminster, Md.					



FBI LABORATORY  
U.S. DEPARTMENT OF JUSTICE

11-1964

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. This correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05856

Reg. Dist. No. 76

## CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Timberly</i>		LENGTH OF STAY (in this place) <i>1 week</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Timberly Nursing home</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Westminster</i>	
3. NAME OF DECEASED (Type or Print) <i>Eda B. Richter</i>		4. DATE OF DEATH <i>June 18 1951</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>1869</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	9. AGE last birthday about 82 yrs.
13. FATHER'S NAME <i>not known</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
16. SOCIAL SECURITY NO. <i>none</i>		14. MOTHER'S MAIDEN NAME <i>not known</i>	
17. INFORMANT AND ADDRESS <i>Mrs. Anna Warner 85 Liberty St. Westminster Md.</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  Immediate cause <i>Generalized Arteriosclerosis</i> Antecedent cause(s) <i>Cholelithiasis - wound infection</i> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>450.0</i> <i>126</i> <i>(c)</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>year</i>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Cholelithiasis</i>			
19a. DATE OF OPERATION <i>Apr 20-1951</i>	19b. MAJOR FINDINGS OF OPERATION <i>Cholelithiasis</i>		
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at m.	HOW DID INJURY OCCUR? Work <input type="checkbox"/> At work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <i>Apr 17, 1951</i> , to <i>June 18, 1951</i> , that I last saw the deceased alive on <i>June 18, 1951</i> , and that death occurred at <i>— m.</i> , from the causes and on the date stated above. SIGNATURE <i>James F. Moran</i> (Degree or title) <i>MD</i> ADDRESS <i>Westminster Md.</i> DATE SIGNED <i>6/20/51</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>June 21-1951</i>	NAME OF CEMETERY OR CREMATORIAL <i>Timberly Cemetery</i>	LOCATION (City, town, or county) <i>Westminster Md.</i>
DATE REC'D BY LOCAL REG. <i>6/20/51</i>	REGISTRAR'S SIGNATURE <i>Reedman</i>	24. FUNERAL DIRECTOR ADDRESS <i>43 Bankhead Non Westminster Md.</i>	

RECEIVED

JUN 22 1951

BUREAU U. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05857

## CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH COUNTY <b>Carroll</b>			2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Md</b>		
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Taneytown</b>			CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Taneytown</b>		
LENGTH OF STAY <i>75 yrs</i>			STREET ADDRESS (If rural, give location)		
HOSPITAL OR INSTITUTION OR STREET ADDRESS					
3. NAME OF DECEASED (Type or Print) <b>Charles</b>		(First) <b>E</b>	(Last) <b>Ridinger</b>	4. DATE OF DEATH <b>June 22, 1951</b>	(Month) <b>June</b> (Day) <b>22</b> (Year) <b>1951</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widower</b>	8. DATE OF BIRTH <b>Dec. 10, 1863</b>	9. AGE last birthday <b>87</b> yrs.	If under 1 year Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired mason</b>			10b. KIND OF BUSINESS OR Industry <b>DAY LABOR</b>	11. BIRTHPLACE (State or foreign country) <b>Md</b>	
13. FATHER'S NAME <b>Isaac Ridinger</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT AND ADDRESS <b>Mrs. Curtis H. Reid Taneytown, Md.</b>	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
<b>592X Immediate cause (a) Chronic Interstitial Nephritis</b>					
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <b>131 a (b) _____ (c) _____</b>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>		(CITY OR TOWN) <b>_____</b>	(COUNTY) <b>_____</b>
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Jan. 14th, 1950., to June 22, 1951.</b> , that I last saw the deceased alive on <b>June 21st, 1951.</b> , and that death occurred at <b>4 A.M.</b> , from the causes and on the date stated above.					
SIGNATURE <b>B.M. Benney M.D.</b>		(Degree or title) <b>ADDRESS</b>		DATE SIGNED <b>June 23, 1951</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>burial</b>		DATE THEREOF <b>June 24, '51</b>		NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State) <b>Lutheran Taneytown Md.</b>	
DATE REC'D BY LOCAL REG. <b>June 23, 1951</b>		REGISTRAR'S SIGNATURE <b>Athel M. McHugh</b>		24. FUNERAL DIRECTOR <b>C.O. FUSS &amp; SON</b>	
				ADDRESS <b>Taneytown, Md.</b>	

RECEIVED  
MAY 19 1951

BUREAU X-6

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Re 05858

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH CITY OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		Carroll MARYLAND Sykesville		LENGTH OF STAY (in this place)		2. USUAL RESIDENCE (HOME) OF DECEASED-STATE Maryland		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN STREET ADDRESS	
				3 days				Baltimore City (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Type or Print)		Eva Snangler Romoser		(Last)		4. DATE OF DEATH 6- 10 1951		(Month) (Day) (Year)	
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single		8. DATE OF BIRTH 12-9-1880		9. AGE last birthday 70 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY X		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Alexander F. Romoser Jr.		14. MOTHER'S MAIDEN NAME Mary Elizabeth Causey		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 10		17. INFORMANT AND ADDRESS Brother - Alexander F. Romoser Jr.	
18. MEDICAL CERTIFICATION									
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH									
Immediate cause 33IX		(a) _____		Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 1 Day			
Antecedent cause(s) 83a		Diseases or conditions, if any. giving rise to the above cause stating the underlying cause last (b) _____		Generalized Arteriosclerosis		3 Yrs.			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		(c) _____							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE		(Specify) INJURY		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 5, 1948, to June 10, 1951, that I last saw the deceased alive on June 10, 1951, and that death occurred at 12:40 A.M., from the causes and on the date stated above. SIGNATURE _____ ADDRESS _____ DATE SIGNED _____ June 10-1951									
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF 6/13/51		NAME OF CEMETERY OR CREMATORIAL Blawood Ridge		LOCATION (City, town, or county) Sykesville, Md.			
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE A.W. Becker		24. FUNERAL DIRECTOR L.M. Pickens & Sons		ADDRESS 72082 Gaithersburg Md.			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

015859

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH COUNTY <u>Carroll</u>		MARYLAND CITY (If outside corporate limits, write RURAL and LENGTH OF STAY OR give nearest town) TOWN <u>Henryton</u> LENGTH OF STAY (in days) <u>6 days</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bishop</u> STREET ADDRESS (If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HENRYTON STATE HOSPITAL</u>					
3. NAME OF DECEASED (First) <u>ISAAC</u>		(Middle) <u></u>		(Last) <u>SHOWELL</u>	
4. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chicken catcher</u>		10b. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>July 7, 1915</u>	
13. FATHER'S NAME <u>Upshur Dennis</u>				9. AGE last birthday <u>35</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>222-03-2106</u>		11. BIRTHPLACE (State or foreign country) <u>Showell, Maryland</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Carrie Showell, Selbyville, Del.</u>				12. CITIZEN OF WHAT COUNTRY?	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
010X Immediate cause (a) <u>Tuberculous Meningitis</u> INTERVAL BETWEEN Antecedent cause(s) ONSET AND DEATH					
14 Disease or conditions, if any, (b) giving rise to the above cause stating the underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 14, 1951, to June 20, 1951, that I last saw the deceased alive on June 20, 1951, and that death occurred at 7:55 a.m., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED <u>Elmer P. Lauer M.D.</u> <u>Henryton, Maryland</u> <u>6/20/51</u>					
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>6-24-51</u>		NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) <u>Long Cemetery</u> <u>Selbyville, Del.</u> (State)	
DATE REC'D BY LOCAL REG. <u>6/20/51</u>		REGISTRAR'S SIGNATURE <u>Alfred B. Swankham</u>		24. FUNERAL DIRECTOR ADDRESS <u>Henry H. Watson Jr.</u> <u>Selbyville</u>	
Deputy Local <u>6/20/51</u>					

RECEIVED  
JUN 26 1951

RECEIVED A.S.

X

VS A15  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Be 05860

## CERTIFICATE OF DEATH

Reg. Dist. No. *DX*

1. PLACE OF DEATH COUNTY CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS			2. USUAL RESIDENCE (HOME) OF DECEASED STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS		
Carroll MARYLAND Sykesville 3 months Springfield State Hospital			Maryland Baltimore (If rural, give location)		
3. NAME OF DECEASED (Type or Print)	(First) Georgianna	(Middle)	(Last) Smith	4. DATE OF DEATH 1872?	(Month) 6 1951 If under 1 year Months 79 yrs. If under 24 hrs. Days If under 24 hrs. Hours Min.
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 1872?	9. AGE last birthday 79 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		
			11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME Elmer Smith			14. MOTHER'S MAIDEN NAME Suzanna Masson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.		
			17. INFORMANT AND ADDRESS Springfield State Hospital records		
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) Coronary occlusion Antecedent cause(s) Generalized arteriosclerosis Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) 12 hours 94a (c) 10 years					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work m. Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from May 13, 1951, to June 5, 1951, that I last saw the deceased alive on June 5, 1951, and that death occurred at 3:50 A.m., from the causes and on the date stated above. SIGNATURE <i>M. Martin</i> (Degree or title) ADDRESS Springfield State Hospital DATE SIGNED Sykesville, Maryland 6/5/51					
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 6-7-1951		NAME OF CEMETERY OR CREMATORIAL Greenmount	
DATE REC'D BY LOCAL REG. 6/6/51		REGISTRAR'S SIGNATURE <i>R.W. Hedrick</i>		LOCATION (City, town, or county) Baltimore (State) Md	
24. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4907 York Rd					

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05861

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## 1. PLACE OF DEATH.

COUNTY Carroll

MARYLAND

CITY (If outside corporate limits, write RURAL and  
OR give nearest town)

TOWN Rural. Sykesville

LENGTH OF STAY  
(in this place)

2 years

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED.

STATE Md.

COUNTY Carroll

CITY (If outside corporate limits, write RURAL and give nearest town)

OR

TOWN Rural. Sykesville

STREET

(If rural, give location)

ADDRESS Shaffer Road.

3. NAME OF  
DECEASED  
(Type or Print)

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED  
(Specify)

8. DATE OF BIRTH

9. AGE last birthday

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT  
COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) If yes, give war or dates of  
service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS

18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

## Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last

## 92 C

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 21. ACCIDENT  
SUICIDE  
HOMICIDE

## (Specify)

## INJURY

## TIME (Month) (Day) (Year) (Hour)

OF  
INJURY

## m.

While at  
Work Not While  
At work 

## INJURY OCCURRED

While at  
Work Not While  
At work 

## HOW DID INJURY OCCUR?

## m.

At work 

## DATE SIGNED

## 22. I hereby certify that I attended the deceased from

## alive on

## SIGNATURE

## (Degree or title)

## ADDRESS

## DATE SIGNED

23. BURIAL, CREMATION  
REMOVAL (Specify)

## DATE REC'D BY LOCAL REG.

## REG.

## DATE REC'D BY LOCAL REG.

## REG.

REGREV  
WIN 26 1957

PREFACE BY S.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05862

## CERTIFICATE OF DEATH

Reg. Dist. No.

77

1. PLACE OF DEATH COUNTY <i>Carroll</i>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i>		COUNTY <i>Carroll</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Greenmount</i>		LENGTH OF STAY (in this place) <i>1 year</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Greenmount</i>		STREET ADDRESS <i>(If rural give location)</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED (Type or Print)	(First) <i>Noah</i>	(Middle) <i>Milton</i>	(Last) <i>Smith</i>	4. DATE OF DEATH	(Month) <i>June</i>	(Day) <i>3</i>	(Year) <i>1957</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Mar 28-1874</i>	9. AGE last birthday yrs. <i>77</i>	If under 1 year Months <i>0</i>	If under 24 hrs. Days <i>0</i>	If under 24 hrs. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Selected colored cotton factory</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Decemiah Smith</i>		14. MOTHER'S MAIDEN NAME <i>Mary A Ruby</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-10-1814</i>		17. INFORMANT <i>Mrs Noah M Smith</i>			

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

## Immediate cause

(a)

*Heart Block**1 yr*

420.0 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last*93d*

(b)

*Atherosclerotic Heart Disease**5 yrs*

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF  
INJURY

m.

INJURY OCCURRED  
While at Work  Not While At work 

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *March 1, 1951*, to *June 3, 1957*, that I last saw the deceasedalive on *June 3, 1957*, and that death occurred at *2:30 P.M.* from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

*W. H. Board**M.D. Manchester, Md June 3-1957*23. BURIAL, CREMATION  
REMOVAL (Specify)DATE THEREOF  
*June 6/51*NAME OF CEMETERY OR CREMATORIAL  
*Greenmount*LOCATION (City, town, or county)  
*Carroll Co Md*

(State)

DATE REC'D BY LOCAL REG.

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BUREAU U. S.

06481

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No.

74

1. PLACE OF DEATH COUNTY <b>Carroll</b> MARYLAND CITY (If outside corporate limits, write RURAL and OR give nearest town) LENGTH OF STAY TOWN <b>Sykesville</b> (In this place)				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Baltimore</b> STREET ADDRESS <b>106 W. North Avenue</b> (If rural, give location)					
3. NAME OF DECEASED (First) <b>HELEN</b> (Middle) <b>ELIZABETH</b> (Last) <b>STEWART</b>				4. DATE OF DEATH June 20 1951 9. AGE last birthday about 47 yrs. If under 1 year Months Days Hours Min.					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SPOUSE MARRIED WIDOWED, DIVORCED, (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH ?	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>John Henderson, Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Carrie A. Smallwood</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Jack Henderson - Hastings-on-the-Hudson, N.Y.</b> INTERVAL BETWEEN ONSET AND DEATH					
18. MEDICAL CERTIFICATION									
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH									
Immediate cause <b>600.0</b>		(a) <b>Fatty liver</b>							
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause <b>186a</b> stating the underlying cause last		(b) <b>Bronchopneumonia</b>							
		(c) <b>Pyelonephritis</b>							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Contusion of brain</b>									
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY?	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>									
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, of office bldg., etc.) <b>Hospital</b>		(CITY OR TOWN) <b>Springfield State Hosp.</b> (COUNTY) <b>Md.</b> (STATE)					
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>6-20-51 7.45 p.m.</b>		INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/> at work <input type="checkbox"/>		HOW DID INJURY OCCUR? <b>Fell out of bed. (9-24-51 - ams)</b>					
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .									
SIGNATURE <b>William J. Stewart</b>		(Degree or title) <b>ADDRESS</b>		DATE SIGNED <b>July 21, 1951</b>					
23. BURIAL, CREMATION REMOVAL (Specify) <b>Cremation</b>		DATE THEREOF <b>6/26/51</b>		NAME OF CEMETERY OR CREMATORIAL <b>Loudon Park Crematory</b>		LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State)			
DATE REC'D BY LOCAL REG. <b>6/25/51</b>		REGISTRAR'S SIGNATURE <b>a w Hendrick</b>		24. FUNERAL DIRECTOR <b>Wm. J. Stewart, son of Patrice</b>		ADDRESS			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05863

## CERTIFICATE OF DEATH

Reg. Dist. No. 76

The correct age

## MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. It is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Rural Westminster</u>		TOWN <u>Rural Westminster</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>P.D. 3</u>		STREET ADDRESS <u>P.D. 3</u>	
3. NAME OF DECEASED (Type or Print) <u>JOHN</u>		(First) <u>THEODORE</u> (Middle) <u>STONESEIFER</u> (Last)	
4. DATE OF DEATH <u>June 26</u>		(Month) <u>1951</u> (Year)	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Jan. 27-1872</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		9. AGE last birthday <u>79</u> yrs. <u>0</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Isaac Stoneifer</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Fornier</u>		15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT AND ADDRESS <u>Ellen Jane Stoneifer Westminster P.D. 3. Md.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause <u>Coronary Thrombosis</u> (a) <u>1 hr</u>			
Antecedent cause(s) <u>Congestive Heart Failure</u> (b) <u>3 yrs</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>420.1</u> <u>94a</u> (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED Whilo at Not While m. Work <input type="checkbox"/> At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Mar 20</u> , 1942, to <u>June 26</u> , 1951, that I last saw the deceased alive on <u>June 22</u> , 1951, and that death occurred at <u>10:30 A.M.</u> , from the causes and on the date stated above. SIGNATURE <u>W. W. Ward</u> (Degree or title) <u>M.D.</u> ADDRESS <u>Manchester, Md.</u> DATE SIGNED <u>6/27/51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>June 27-1951</u>	
DATE RECEIVED BY LOCAL REG. <u>6/27/51</u>		NAME OF CEMETERY OR CREMATORIAL <u>Baltimore Cemetery</u>	
REGISTER'S SIGNATURE <u>Howard</u>		LOCATION (City, town, or county) <u>Westminster</u> (State) <u>Md.</u>	
24. FUNERAL DIRECTOR <u>H. Barkard &amp; Son, Westminster, Md.</u>		ADDRESS <u>100105</u>	

**RECEIVED**

JUL 1 1951

**BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05864

## CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH COUNTY Carroll			2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md COUNTY Carroll		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Middleburg			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Middleburg		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)		
3. NAME OF DECEASED (Type or Print) Robert			4. DATE OF DEATH June 19 1951		
(First) J. (Middle) Walden			(Month) (Day) (Year)		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 5/10/1871	9. AGE last birthday 80	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) horse trainer			10b. KIND OF BUSINESS OR INDUSTRY race horses		
13. FATHER'S NAME R.W. Walden			11. BIRTHPLACE (State or foreign country) New York 12. CITIZEN OF WHAT COUNTRY USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. none 17. INFORMANT AND ADDRESS Mary Norris Walden Middleburg, Md.		

MARGIN RESERVED FOR BINDING

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION <i>Arteriosclerotic C-V disease</i>	INTERVAL BETWEEN ONSET AND DEATH <i>years</i>
Immediate cause (a)				
Antecedent cause(s) (b)				
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)		(COUNTY) (STATE)
TIME (Month) OF INJURY	(Day) (Year) m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from _____, 1946, to June 19, 1950, that I last saw the deceased alive on June 19, 1951, and that death occurred at 2 p.m., from the causes and on the date stated above.		
SIGNATURE <i>James T. March M.D.</i>	(Degree or title) ADDRESS <i>Westminster Md.</i>	DATE SIGNED <i>6/20/51</i>

23. BURIAL, CREMATION REMOVAL (Specify) burial	DATE 6/22/51	NAME OF CEMETERY OR CREMATORIAL Middleburg	LOCATION (City, town, or county) Middleburg	(State) Md.
DATE REC'D BY LOCAL REG. June 22 1951	REGISTRAR'S SIGNATURE <i>Ethel M. Mehling</i>	24. FUNERAL DIRECTOR C.O. FUSS & SON ADDRESS Tanwyttown, Md.		

RECEIVED  
FEB

JUN 25 1931  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05865

## CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY		Carroll MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE		Maryland COUNTY		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		Sykesville LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		Baltimore		
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Springfield State Hospital		STREET ADDRESS		Phila Rd & Ridge Rd		
3. NAME OF DECEASED (Type or Print)		(First) Margaret	(Middle) Matilda	(Last) Wallace	4. DATE OF DEATH	(Month) 6	(Day) 29	(Year) 1951
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year	If under 24 hrs.		
female	white		3/19/03	48 yrs.	Months	Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Housewife		at Home		Maryland				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
Frank Dixon		Catherine Ruffing						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS		Springfield State Hospital records		

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH			
Immediate cause	(a) Cerebral hemorrhage	4 days			
331X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized arteriosclerosis	1 year			
83a	(c) Hypertension	?			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work m.	HOW DID INJURY OCCUR?			
	Not While At work <input type="checkbox"/>				

22. I hereby certify that I attended the deceased from 7/22/1950, to 6/29/1951, that I last saw the deceased

alive on 6/28/1951, and that death occurred at 9:00 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED  
Springfield State Hosp. 6/29/51  
Sykesville, Maryland

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)
Burial	7-2-51	Sacred Heart	Derman Bell Rd	Md
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
7-2-51	awedward	John S Connell	418 Eastern Ave	Baltimore 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05866

## CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Carroll		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Westminster LENGTH OF STAY <i>(In this place)</i>			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster		
HOSPITAL OR INSTITUTION OR STREET ADDRESS 179 W. Main Street			STREET ADDRESS 179 W. Main Street (If rural, give location)		
3. NAME OF DECEASED (Type or Print) James Pearre Wantz			4. DATE OF DEATH June 26 1951		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Apr. 30, 1879	9. AGE last birthday 72 yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>			10b. KIND OF BUSINESS OR INDUSTRY National Bank		
13. FATHER'S NAME Charles V. Wantz			14. MOTHER'S MAIDEN NAME Caroline V. Pearre		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 213-01-9145		
17. INFORMANT AND ADDRESS Jas. Pearre Wantz, Jr. Westminster			12. CITIZEN OF WHAT COUNTRY? USA		
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) <i>Ventricular fibrillation</i> Antecedent cause(s) (b) <i>Cardiac failure</i> Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) <i>Hypertension Cardiovascular Renal Disease 5 years</i>					
INTERVAL BETWEEN ONSET AND DEATH <i>3 hours</i> <i>24 hours</i> <i>5 years</i>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work m. Not While At work		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>9 Sept</i> , 1949, to <i>26 June</i> , 1951, that I last saw the deceased alive on <i>26 June</i> , 1951, and that death occurred at <i>12:45 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>G Allen Moulton MD.</i> ADDRESS <i>Westminster, Md. 622-57</i> DATE SIGNED <i>6/29/51</i>					
23. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>June 29, 1951</i>		NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) <i>Krider's Cemetery</i> (State) <i>nr Westminster, Md.</i>	
DATE REG'D BY LOCAL REG. <i>6/29/51</i>		REGISTRAR'S SIGNATURE <i>G. Allen Moulton</i>		24. FUNERAL DIRECTOR ADDRESS <i>John R. Byers</i> <i>Westminster, Md.</i>	

**RECEIVED**

JUL 1 1951

**BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05867

76

Reg. Dist. No.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

Carroll

CITY (If outside corporate limits, write RURAL and  
OR give nearest town)TOWN Rural, Westminster

HOSPITAL OR

INSTITUTION OR

STREET ADDRESS

MARYLAND

LENGTH OF STAY  
(in this place)About 6 yrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

COUNTY

Maryland

Carroll

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN

STREET

ADDRESS

(If rural, give location)

Rural, WestminsterLittlestan Road3. NAME OF  
DECEASED  
(Type or Print)HOWARD WILSON WAREHIME

(First)

(Middle)

(Last)

4. DATE  
OF  
DEATH

June

(Month)

12

(Day)

1951

## 5. SEX

m.

## 6. COLOR OR RACE

W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

Widowed

## 8. DATE OF BIRTH

July 5, 1868

## 9. AGE last birthday

82

yrs.

If under

1 year

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)retired farmer10b. KIND OF BUSINESS OR  
INDUSTRY-

## 11. BIRTHPLACE (State or foreign country)

Meadow Branch Carroll Co.12. CITIZEN OF WHAT  
COUNTRY?A.S.A.

## 13. FATHER'S NAME

David Warehime

## 14. MOTHER'S MAIDEN NAME

Sarah Ann Riggle15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of  
service)422.193d

## 16. SOCIAL SECURITY NO.

- - - - -

## 17. INFORMANT AND ADDRESS

Walter S. Warehime

## Baltimore, Md.

Bld So. Belfield Ave.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

acute cardiac decompensation

## (a)

## Antecedent cause(s)

arteriosclerosis -myocarditis6 yrs.2 yrs.Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last(b)

## II. OTHER SIGNIFICANT CONDITIONS

## Conditions contributing to the death but not

## related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes No 21. ACCIDENT  
SUICIDE  
HOMICIDE

## (Specify)

## TIME (Month) (Day) (Year) (Hour)

OF  
INJURY

m.

## INJURY

While at

Work

Not While

At work

PLACE (Home, farm, factory, street,  
of office bldg., etc.)

## INJURY

## INJURY OCCURRED

While at

Work

Not While

At work

## (CITY OR TOWN)

## (COUNTY)

## (STATE)

## HOW DID INJURY OCCUR?

m.

Work

At work

m.

At work

REGEIVED  
JUN 18 1958

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

05868

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH COUNTY CARROLL		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Rural - Sykesville		LENGTH OF STAY (in this place) 1 month, 7 days	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Westminster	
		STREET ADDRESS 165 West Main Street	
3. NAME OF DECEASED (Type or Print) ABRAHAM REAMO		4. DATE OF DEATH 6 1 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 2/21/91
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) handyman CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY CAMPING NEADE + HOLA BUD	
13. FATHER'S NAME William H. Whitehurst		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? USA	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Mary Redsecker	
17. INFORMANT AND ADDRESS Record, Springfield State Hospital		18. MEDICAL CERTIFICATION	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis 3 hrs.

Antecedent cause(s) (b) Arteriosclerotic heart disease indefinite

Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with chronic alcoholism, Deterioration

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED White at Not White m. Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/21, 1951, to 6/1, 1951, that I last saw the deceased

DST

alive on 6/1, 1951, and that death occurred at 4:45 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title) M. D.

Sykesville, Maryland

DATE SIGNED 6/1/51

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL	DATE THEREOF June 1-1951	NAME OF CEMETERY OR CREMATORIAL RIDERS	LOCATION (City, town, or county) CEMETERY WESTMINSTER	(State) MD.
DATE REC'D BY LOCAL REG. June 2, 1951	REGISTRAR'S SIGNATURE Orlan Wees	24. FUNERAL DIRECTOR H. Barnard Son Westminster Md.		

RECEIVED  
MAY 6 1951

BUREAU U.S.



RECEIVED

JUN 13 1951

BUREAU A. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Be 05870

## CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH: COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland		COUNTRY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Gamber		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer Park Road		STREET ADDRESS (If rural, give location) 2016 Cliftwood Ave Balto Md					
3. NAME OF DECEASED (Type or Print) Carroll		(First) Carroll	(Middle) Solomon	(Last) Zepp	4. DATE OF DEATH June 17		(Month) (Day) (Year) 1951
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED		8. DATE OF BIRTH Oct 27 1883	9. AGE last birthday 67		If under Months yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Defense Plant		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Howard S. Zepp		14. MOTHER'S MAIDEN NAME Alverta Gore					
15. WAS DECASSED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-01-8857		17. INFORMANT AND ADDRESS Mrs Marion Moulden		2016 Cliftwood Ave Baltimore Md	

MARGIN RESERVED FOR BINDING

VS. A15 PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION <i>Primary Anemia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>
293	Immediate cause (a)			
75c	Antecedent cause(s) (b)			
	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<i>Splenectomy</i>		
19a. DATE OF OPERATION <i>May 1951</i>	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)		(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>6-14-57</i> , 19 <i>57</i> , to <i>6-17-57</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>6-16-57</i> , and that death occurred at <i>7 P.m.</i> , from the causes and on the date stated above. SIGNATURE <i>John G. Salter M.D. Rockville Md</i> DATE SIGNED <i>6-19-57</i> <i>ADDRESS</i>				
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE June 20 1951	NAME OF CEMETERY OR CREMATORIUM Calvary Meth. Cemetery	LOCATION (City, town, or county) Gamber	(State) MD
DATE REC'D BY LOCAL REG <i>6/19/51</i>	REGISTRAR'S SIGNATURE <i>John G. Salter</i>	FUNERAL DIRECTOR Wm Berryman & Sons Reisterstown Md	ADDRESS <i>770449</i>	

RECEIVED  
JUN 22 1951

BUREAU U.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05871

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Sykesville		LENGTH OF STAY (In this place) 3 yrs, 6 mos.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital		STREET ADDRESS Unknown		(If rural, give location)	

3. NAME OF DECEASED (Type or Print) Milbourn	(First)	(Middle)	(Last)	4. DATE OF DEATH June 29	(Month)	(Day)	(Year) 1951
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Sep.	8. DATE OF BIRTH 11-14-03	9. AGE last birthday 47	If under 1 year Months	If under 24 hrs Days	If under 24 hrs Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe fitter		10b. KIND OF BUSINESS OR INDUSTRY Ship-yard	11. BIRTHPLACE (State or foreign country) Frederick Co., Md.	12. CITIZEN OF WHAT COUNTRY United States			
13. FATHER'S NAME Howard Victor Zimmerman		14. MOTHER'S MAIDEN NAME Jennie Auschermann					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT AND ADDRESS Records - Springfield State Hospital				

18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) Bronchopneumonia							
491X Antecedent cause(s) (b) Psychosis with Huntington's Chorea							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)							
107							

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?
-----		-----		-----		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE -----	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY)
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at m. Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?		(STATE)
OF INJURY -----		m.		-----		

22. I hereby certify that I attended the deceased from Sept. 1 1947, to June 29 1951, that I last saw the deceased alive on June 29, 1951, and that death occurred at 8:33 A.m., from the causes and on the date stated above.  
SIGNATURE Martin Gross, M.D. (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 6-30-51	NAME OF CEMETERY OR CREMATORIAL REG. C. Harry Zeller	LOCATION (City, town, or county) Frederick, Md.
DATE REC'D BY LOCAL REG. June 30, 1951	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS M. R. Etchison & Son, Frederick, Md.	

